UCI Health

MR#: _____

DOB: _____

Media and Community Relations Authorization

I authorize UCI Health to release my protected health information for the following uses:

□ I voluntarily give permission for photographs, film or videotape of me to be taken and used by news media, UCI Health staff or their representatives for communicating events, programs, procedures and the like. I understand once released to the media, UCI Health retains no further control over their use.
□ I voluntarily give permission for medical information regarding my medical condition or treatment to be released to the news media, UCI Health staff or their representatives for news stories or other communications (TV, radio, newspapers, magazines, web sites or video news release).

I authorize the release to: UCI Health/News Media/_____

NOTICE: UC Irvine Healthcare is required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws from re-disclosure.

YOUR RIGHTS: This authorization to release health information is voluntary. You are not required to sign this authorization to receive treatment or for payment of care, health plan enrollment or eligibility for benefits.

The following will not be released unless you specifically authorize it:

- The release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and §§2.35).
- The release of information pertaining to mental health diagnosis or treatment (Welfare & Institutions Code §§5328, *et. seq.)*
- The release of HIV/AIDs test results (Health and Safety Code §120980 (g)).
- The release of genetic testing information (Health and Safety Code §124980 0)).

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and sent to UCI Health Media Relations, 333 City Blvd. S., Ste. 1250, Orange, CA 92868.

The revocation will take effect upon receipt, except to the extent UCI Health or others have already relied on it. You are entitled to receive a copy of this authorization.

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this authorization expires 12 months from the date of your signing this form.

_____
Print Name

_____
Relationship to Patient

_____
Signature (Patient/Parent/Guardian)

_____
Phone Number

_____
Date

_____
Witness (name of staff member handling this form)

_____
Time